# Michelle H. v. Haley – Experts' Review of SCDSS Health Plan

## Summary of Priority Actions

**Submitted by Gail Nayowith and Kathleen Noonan**

**February 12, 2018**

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**The Experts' full report begins on page three of this document. This summary identifies six priority actions from the full report that DSS should commence immediately.**

Recognizing that full implementation of the Health Plan will roll out over a period of several years, we offer a short list of actions to help DSS jumpstart the work ahead. Work on these actions should start before a revised Health Plan is completed. We see these near-term actions as necessary in light of the scale of this effort and because the terms of the settlement require attention to the health needs of children in foster care today.

We recommend **six priority actions**, outlined below, to be undertaken right away:

1. **Produce a Revised Health Plan**
2. **Identify an Interim Director of the DSS Office of Health and Well-Being**
3. **Identify and Convene a SWAT Team**
4. **Obtain Gap in Care Reports from HHS and SH**
5. **Initiate Short-Term Data Work-Around to Mitigate the 30-Day Enrollment Gap**
6. **Initiate Short-Term Plan to Address Immediate Needs**

### 1. Produce a Revised Health Plan

As outlined in the report, SCDSS should develop a revised Health Plan that includes implementation timeframes, task leads and staffing, technology and other resource need, including a multi-year budget.

### 2. Identify an Interim Director of the DSS Office of Health and Well-Being

Name an Interim Director to fill this essential position drawing on internal staff or by detailing a staff person from another state agency, preferably SCDHHS, to take on this critical leadership role. If the job posting has not produced a sufficient candidate pool, retain a search firm to source candidates.

### 3. Identify and Convene a SWAT Team

Convene a SWAT Team comprised of SCDSS and SCDHHS leads, and SH staff as needed to begin meeting weekly to develop a work plan and implementation tracker and begin to monitor: progress made to implement these recommendations and other elements in the revised Health Plan, troubleshoot and resolve issues or conflicts that arise; and, provide bi-weekly progress reports to the SCDSS and SCDHHS Commissioners and monthly reports to the Co-Monitors.

**4. Obtain Gap-in-Care Reports from HHS and SH**

SCDSS will work with SCDHHS and other relevant state agencies, and SH if needed, to develop a data-sharing agreement to be completed in six months, as outlined earlier in the report. In the interim, SCDSS, SCDHHS, and SH as needed, can produce a Gap-in-Care Report that identifies foster children who have not received required screenings, assessments or follow up. The roster produced should be used by the SWAT Team to monitor completion of these activities for all children listed on the roster. The SCDSS can develop a protocol for notifying caseworkers about children who have missed required screening, assessment or follow-up visits and for tracking completion of all required activities.

**5. Initiate Short-Term Data Work-Around to Mitigate the 30-Day Enrollment Gap**

Develop and implement a data work-around until SCDSS and SCDHHS create a structural solution to the 30-day enrollment lag into SH, as described in the report. The idea is to create a 1st 30 Days Report to avoid children getting lost in the first 30 days after entry into care. To accomplish this, SCDSS can create a weekly roster of all new entrants into foster care and with assistance from SCDHHS match the roster to the child or family's Medicaid ID. The Medicaid ID can be used to pull relevant claims and encounter data for children on the roster. This information can be fed to caseworkers for follow-up. The roster will flag children who have entered foster care in the last 30 days who have not received screening, assessment or follow up. The SWAT Team can create a protocol to share this report with caseworkers and SH to promote continuity of care and monitor completion of required activities in the first month of placement.

**6. Initiate Short-Term Plan to Address Immediate Needs**

The new 1st 30 Days and Gap-in-Care Reports can be used to identify children with immediate needs. A case-specific Immediate Needs Tracker Report can be developed to capture for any given period of time a roster of children who have not received screenings, assessments or follow-up. The protocol described above can include guidance for caseworkers on how to engage SH to expedite required screenings, assessments and follow-up needed., The SWAT Team can monitor completion of required screening, assessment and follow-up.

# Michelle H. v. Haley – Experts' Review of SCDSS Health Plan

## Findings and Recommendations – Full Report

**Submitted by Gail Nayowith and Kathleen Noonan**
**February 12, 2018**

## I. Introduction

The Final Settlement Agreement (FSA) in Michelle H. v. Haley requires the South Carolina Department of Social Services (SCDSS) to develop a Health Care Improvement Plan (the "Plan") for all children involuntarily placed in DSS foster care in the physical or legal custody of DSS. The Plan is subject to the approval of Co-Monitors Judith Meltzer and Paul Vincent, who under the FSA, have the ability to engage expert contractors "to assist in the development and monitoring of the" Plan. (See Section IV.K). Pursuant to that authority, the co-monitors retained Gail B. Nayowith and Kathleen Noonan to "validate" the Health Plan submitted by DSS on September 29th, 2017.

Specifically, the experts agreed to validate the "infrastructure components," "innovations" and targets as described in the proposed Plan, and identify gaps, if any, in a Findings and Recommendation report.

This Findings and Recommendations report proceeds in four parts: Part I offers an overview of the report. Part II is the methodology including the sources of information used in this discovery and assessment phase of work. Part III includes our findings and assessment of whether the plan element as presented is fine as is = **Concur**, whether it should remain in the Health Plan but needs revision = **Concur with Revisions**, or whether the element should be removed from the Plan = **Do Not Concur**.

As an overall finding, the SCDSS Health Plan submitted to the Court includes important conceptual and structural elements on which to build a robust health system for children in foster care. It does not yet include the operational framework needed for implementation.

In Part IV we propose a reorganization and rethinking of the key building blocks of the SCDSS Health Plan. We offer amendments or alternatives to some core features of the Plan (Concur with Revisions). We also note the need to establish implementation timeframes, identify task leads and describe the staffing, technology, financial or other resources necessary to operationalize the Plan. Further, the Department's efforts to recruit and hire a senior person with the skills and authority to lead the work to modify, operationalize and implement the health plan is an imperative. The revised Plan should include a multi-year phase-in calendar and an estimated budget.

We also include some short-term actions that DSS should take immediately to move the planning and implementation process along. Most urgent, is the need to establish a new cross-agency project management team with high level representatives with decision-making authority from SCDSS, SCDHHS and Select Health (SH). In the short-term, we recommend convening this as a weekly "SWAT Team" leading up to the production of a revised Health Plan to be submitted to the Co-Monitors and the Court. The SWAT Team could work through the most critical elements of the Plan including: developing a data sharing agreement and framework for data use and reporting; articulating the differentiated roles and responsibilities for DSS and IFCCS caseworkers, SH care coordinators and case managers; solving the 30-day enrollment gap to expedite enrollment of children entering foster care into SH, and refining the timelines and targets for key screenings, assessments and services built on AAP guidelines. We also

recommend moving quickly to generate a gaps-in-care data report to identify children who may need prompt attention.

For the revised Plan, we suggest a focus on six core functions that build on and add to original Plan elements:

1. Governance
2. Data Sharing and Reporting
3. Enrollment
4. Care Coordination and Care Management
5. Network Adequacy, Access to Services and Immediate Needs
6. Targets

# II. Methodology

We reviewed and considered the elements of the SCDSS Health plan, including its nine infrastructure components, seven innovation areas and select targets, and developed a validation framework to guide our assessment. We sought to examine reports, data, policies and practices already in place. We did not ask SCDSS to create new tools or reports and instead worked from data that is already collected and documents already in use to better understand the operating environment in which the SCDSS Health Plan will be implemented.

The methods used to verify the various plan elements included phone interviews (Appendix), in-person meetings (Appendix), a focus group with foster parents, extensive documentation and data review (Appendix), a hands-on review of the SCDSS CAPSS system and reports, a review of the Medicaid encounter (services provided) and claims data and the SCDHHS MMIS data system, and observation. We considered a case record review. We spent three days on the ground with SCDSS in early January 2018.

# III. Validation Findings

## Infrastructure

### 1. Select Health

The choice of a single MCO for children and youth in foster care is a solid strategy for the delivery of health and mental health services. This element is central to South Carolina's Health Plan. The contract between SCDHHS and Select Health (SH) specifies the essential elements, core requirements and necessary practices as relates to the provision of health care to children in foster care. All children in foster care in SC (approximately 4200) are immediately eligible for Medicaid upon entry into foster care placement. All children in foster care are enrolled in the SH health plan within 30 days. This lag creates significant complications that are discussed later in the report.

The SCDHHS/SH contract does not yet acknowledge a role for, or accountability to, the SCDSS. We recommend a reset in the governance relationship between SCDSS, SCDHHS and SH, which is described in detail in the Part IV.

| **Concur with Revisions** |
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**2. The Foster Care Advisory Committee**

The re-activated Foster Care Advisory Committee (FCAC) is an important opportunity to bring the SC child serving community together, including both internal and external stakeholders. The FCAC should serve in an advisory capacity, bringing expertise to DSS that informs practice, program and policy development, offering feedback from the field and community, and otherwise offering expertise and guidance on relevant issues like caseworker training, casework practice or clinical quality and the like. The structure of the FCAC should remain flexible so that work groups and members can change as work is completed or new needs emerge. The schedule of quarterly meetings with as-needed work group meetings in between should continue. The FCAC may benefit from an updated charter or statement of purpose to orient members as to their roles and responsibilities.

However, the FCAC – an advisory body that meets on a quarterly basis – cannot be responsible to design or implement the new Health Plan. Instead, as described in our Recommendations, DSS needs a new approach to governance, staff assigned full-time to lead this effort and a reset in its relationship to SCDHHS and SH.

**Concur with Revisions**

**3. Child and Adolescent Psychiatrist**

This position now held by Dr. Khetpal serves, in effect, as a Chief Medical Officer (CMO) for DSS. The CMO's responsibilities are detailed in the Plan. Dr. Khetpal is highly regarded by SCDSS staff, by SCDMH and SCDHHS. Her part-time position brings new clinical, health care and psychopharmacology expertise and depth to DSS. Consideration should be given to building out this function.

However, this position is not properly called "Infrastructure" as labeled in the Plan. This essential position is more accurately described as an enhanced clinical staffing resource to DSS operating under the aegis of the new Office of Health and Well-Being. Consideration should be given to making this a full-time position or bringing on additional part-time capacity to support the clinical work. Our understanding is that Dr. Khetpal serves as a clinical consultant, not as a manager lead for DSS. Dr. Khetpal is in a good position to identify clinical staffing resources that would be needed for the new Office.

**Concur with Revisions**

**4. CAPSS Health Screens and the Electronic Health and Education Passport**

The electronic record, called CAPSS has the potential to improve both individual child and system-level outcomes, and should replace any paper health records in SCDSS files as soon as is practicable. The time and effort that SCDSS has invested in developing CAPSS will be helpful for the significant work ahead to develop data sharing capacity with HHS and SH.

At this time, caseworkers are hand entering essential health data and trying to piece together health histories on the approximately 4200 children in care from data reported by foster parents or health care providers. This data is already collected by SCDHHS and the contracted MCO - Select Health. The SCDHHS Medicaid Management Information System (MMIS) and SH data system already tracks services provided

(encounter data), claims paid and so forth. We do not believe it is a good use of caseworker time to recreate health care data that is collected with more accuracy and in less time by HHS and SH. Whenever possible, the source of CAPSS data and the E&H Passport entries should be generated to the fullest extent from HHS and SH data feeds. The state's MMIS data, along with contractual reporting requirements for SH, allows for continuous tracking of enrollment, services provided (encounters), gaps in care and other utilization and quality metrics. Because it is a system of record, it can generate timely data that is more reliable than data collected now by hand by SCDSS caseworkers. It should become the basis for populating CAPSS, thereby creating an electronic health record for all children in DSS custody.

DSS and DHHS have begun to sync up their data to create a synchronized roster of eligible children, and are working now to move any remaining children who are not coded as "foster care" into that status. Medicaid claims, service and utilization data from the SCDHHS system of record and SH should populate, along with other ancillary information, the official CAPSS health record for all children in foster care. This is not only important for children while they are in foster care, but will be critical medical history that can follow children once they transition out of foster care. While we understand that setting up a data-sharing exchange will take time and the patience of all involved, it presents an opportunity for SC to be a national model with respect to the health of children in foster care. While we were on site, HHS, SH and DSS verbally agreed to develop a data sharing agreement and protocols for regular data feeds. Protocols will have to be developed around data access and a set of reports to be created. See our Recommendations for more detail on data sharing.

**Concur with Revisions**

**5. Data Gathering and Initial Health Assessment Data**

Pursuant to our observation in the previous section, we recommend that DSS focus its efforts on securing a data-sharing agreement with HHS and SH, engage in the development of a Medicaid data capture report on initial screenings and health assessments and secure a *gaps-in-care* report from SH and/or the SCDHHS MMIS. We address the 30-day enrollment gap in our Recommendations.

As a general rule, we do not support the creation or use of ad hoc data or reports pulled from hand-entered health care records. From what we have reviewed, it appears that already stretched caseworkers are being diverted from critical casework tasks to chase health information because there is no data link between DSS, HHS and SH. The result – very likely – is the collection of highly inaccurate information. For the time being, caseworkers are patching together health histories and services needed, but it is not a good long-term solution. We understand that SCDSS developed this approach as a work-around in the absence of critically needed information. Delays in securing information on initial health screenings and assessments is complicated by the fact that children in foster care are not enrolled in SH the day they enter care. This means that the caseworkers and foster parents who must meet SCDSS timeframes for screenings, assessments, and care for immediate needs are in a position of having to juggle appointment scheduling, follow-up visits and also chase down essential screening, assessment and referral information from a child's prior provider. Given the opportunities afforded by having SH as the single MCO for all children in foster care, it seems to run counter to intent to rely on screenings, assessments or treatment plans developed by other plans and providers. In addition to accessing SCDHHS and SH data and tracking, it will also be necessary to address the 30-day enrollment lag.

**Do Not Concur**

### 6. Immediate Treatment Needs Identification

This plan element was created in direct response to the lawsuit. Per the discussion above, to meet the conditions of the settlement agreement, a caseworker-dependent workaround was developed in the absence of other sources of data. We recommend against this work-around because we believe DSS should be working with the Medicaid health data (MMIS) through HHS and SH to identify the treatment needs, services rendered or gaps in care for children in custody. Caseworker and supervisory staff resources should, in the short run, be devoted to making sure that children get to medical appointments and receive the care they currently need, not to tracking down historical data. There could be a way to generate a look-back report for a specified time period for a defined cohort of children in foster care to determine whether immediate needs were met. We have requested data from SH to begin the process of identifying children who have screening, assessment and service needs. This should be happening concurrent with the development of a data sharing agreement.

In addition, while we understand that "immediate treatment needs" is defined in the settlement agreement, we think it may be overbroad and poorly understood in the health care sector. DSS could develop a robust "treatment needs" framework that categorizes needs in language that is consistent with how they are captured in the health care world. For example, in our meeting with DMH, they framed MH needs as "routine, urgent or emergent." Our Recommendations include more a more detailed discussion of this issue.

**Concur with Revisions**

### 7. Healthcare Needs Assessment Survey

The survey findings are extensive and point to significant service, access and availability gaps in the counties. A companion study is needed to follow-up on this work and to ascertain network adequacy and timely availability of services. This capacity analysis would use administrative data and a set of proxy measures to answer the questions of adequacy and availability. Further, the MCO contract between SCDHHS and SH is conditioned on having an adequate provider network and timely access to services and there are penalties associated with failure to do so. As it stands, we consider this survey to be enhanced context to inform the Health Plan. We do not consider this survey an "infrastructure" component as described in the Plan. We address the issue of network adequacy and access to services in the Recommendations.

***Concur with Revisions***

### 8. Training

We have not seen a training plan or training calendar for caseworkers or supervisors. This is a critical infrastructure element that should be elaborated upon in the revised Plan. We spoke to a number of stakeholders who verified that training related to psychotropic medications and case record review had taken place. This training is focused narrowly on psychotropic medication issues or federal compliance

activities. It is unclear whether other health, behavioral health and other health-related training is made available to caseworkers and supervisors. The training plan and calendar should be generated by the new Office of Child Health and Well-Being. However, it is our opinion that there may be other critical building blocks that need to be put in place first, before DSS embarks on creating, purchasing or offering other health-related trainings or bringing a learning management system on line.

***Concur with Revisions***

**9. Office of Health and Wellbeing**

The new Office of Health and Wellbeing should play a central role in the development, implementation and monitoring of the DSS Health Plan. By creating this office, DSS can centralize and direct agency activities related to child health, as well as coordinate the extensive inter-agency and community engagement work that is envisioned by the Plan. We discuss the role of this Office in greater detail in our Recommendations. The role, scope of work and leadership authority of the office needs to be more clearly defined, including identifying specifically its role in Plan implementation. Work is underway to recruit a Director for the new Office of Health and Well-Being and the position has been posted. This is a critical position and essential role in the SCDSS Plan.

***Concur with Revisions***

## Health Care Plan Innovations

**1. Case Managers to coordinate care for all children and youth in foster care. SCDSS will work with SCDHHS and Select Health to agree to an appropriate caseload for CMs.**

DSS, HHS and SH are in agreement that they need to work together to develop a tiered (health) care coordination function. This is a critical component of the Health Plan, and needs significant attention, which we discuss in the Recommendations. This includes defining and describing the SH care coordination role, and defining the DSS case worker role. Both functions are necessary and DSS and SH will have to develop guidelines, training, work flows and protocols.

**Concur**

**2. Assign all SC foster care children to a QTIP[1] or other medical home practice of similar quality**

The QTIP program was developed with CHIPRA demonstration funds, but is now an ongoing program of HHS. A process and recruitment plan is needed to identify additional providers who could be certified as "QTIP-like" preferred providers in terms of the quality of practice (proficiency in AAP - Bright Futures approach among other things), and specialized knowledge/training/expertise in working with children in foster care. We discuss this in the Recommendations.

**Concur**

### 3. Leverage the SCDHHS Palmetto Coordinated System of Care 1915(c) waiver

The 1915(c) waiver promises to be a very important service for children and youth with SED in South Carolina. To date, SCDHHS has not submitted its waiver request to CMS and the waiver has not been approved. Consequently, it is too early to include this resource in the SCDSS Health Plan waiver. Work is underway to establish the basic infrastructure for the program which will have capacity to serve a limited number of children (our understanding is approximately, 200 in year 1 growing to 600 at full implementation). Eligibility for the program will include SED and a history of hospitalization. Children will be enrolled on a first-come, first-serve basis, with no guaranteed availability for children in foster care. The absence of slot guarantees for children in foster care and the nascent stage of program development, limit our ability to credit this as a Health Plan resource or "innovation" at this time. This said, we strongly encourage SCDSS and SCDHHS to continue planning for the roll-out of these necessary services to eligible foster children.

**Do Not Concur**

### 4. Monitor Health Outcomes Using Data

The importance of this element of the Plan cannot be overstated. It is our strong recommendation that quality, utilization, tracking and other reports must be generated from SCDHHS or SH data systems of record. There should be little need for DSS to create its own health data. If the health, dental and behavioral health data feeds from MMIS or SH into CAPSS, the CAPSS records could also be mined for data reports. We elaborate on this earlier in our report. In addition, we have requested that DSS obtain data from SH in the short-term that should answer some basic questions on level of need and services currently provided to children in foster care. It will be important for DSS, as part of its Health Plan, to identify opportunities for health data to be used at the state and local level to actively track the health care needs of children in care. See our Recommendations for more detail.

**Concur**

### 5. Enhanced Case Practice

Enhanced case practice is complicated by two competing approaches to case management in the Department. Another layer of complexity is caused by misunderstanding SH's care coordination role. Clarity is needed to differentiate the roles, responsibilities, practices and caseload sizes of SCDSS caseworkers and IFCCS case workers. The development of a new health-informed practice model needs to be incorporated into a broader discussion about care coordination.

Currently, there is substantial role uncertainly around the case management and care coordination functions, which needs attention. This relates to the roles of DSS, HHS, SH as well as foster parents. Care coordination must be a central plan element, but it is not currently well-defined or clearly understood. This is addressed in more detail in the Recommendations.

***Concur with Revisions***

### 6. Enhanced Training and Partnerships with Foster Parents and Group Care Providers

DSS has some core foundational work to do with HHS and SH before it can train foster parents or group care providers on its new health care practices and requirements. However, this training is necessary and viewed as infrastructure for the Plan. A health and behavioral health training curriculum for foster parents could be developed by the foster care support organizations or a local university or by DSS in partnership with SH. It would be useful to resolve an ongoing question about whether foster parents should choose the child's health care provider or whether the child should be assigned by SH to a Q-TIP or Q-TIP look-alike provider. We think this could be done by creating a presumption that children will be assigned by SH, but that foster parents have the option to use their own provider (or choice of provider) so long as they notify SH of this designation. In other words, we would not recommend a strict rule, but rather a presumption that allows for flexibility on the ground.

**Concur**

### 7. Engagement with the South Carolina Department of Mental Health

At this point, DMH's electronic records are not coded to identify children in foster care. It is not clear to us that doing so would be necessary since SH captures encounter data and would be the payer for BH services rendered by DMH. It would certainly be worth looking into, but secondary to obtaining accessing to the SH data.

What DMH offers to DSS is a network of clinics and providers around the state, including in remote/rural areas, which could be offered as a walk-in service and for scheduled visits as needed. DMH seemed open to more formal arrangements perhaps as a preferred provider for children in foster care. This preferred provider status could be discussed with DSS, DHHS and SH.

**Concur with Revisions**

## Health Care Targets

See our earlier discussion of initial health screens above and immediate treatment needs, and the need for alignment of SCDSS and SCDHHS/SH timeframes**.** It seems premature to set these targets before further discussions among DSS, HHS and SH about sharing data, and about protocols and timeframes related to initial screenings and assessments. DSS will need to work with the Co-Monitors, as set forth in the Settlement Agreement, on the development of targets.

### 1. Initial Health Screens

Achieving a standard of initial health screens with 14 days of a child entering care cannot be met without addressing the 30-day enrollment lag, discontinuity of providers, and poor sources of data. These targets should be reviewed with DHHS and SH as part of the discussion around aligning timeframes and moving to standardized screening and assessment tool(s).

### 2. Immediate Treatment Needs

Per our comments above, we recommend setting targets related to this as part of discussions with DHHS and SH on data, treatment approach, etc. The next steps to do this would be through discussions among DSS, DHHS and SH. These discussions would include some agreement on the "look back" parameters defining immediate needs as promised in the Settlement Agreement, as well as an agreement on how regular tracking of immediate needs will be handled going forward. At this point, weekly SWAT Team meetings are needed to move urgent items forward. We recommend that DHHS data be used to generate a gaps in care report. This report will identify children needing attention. SCDSS can use the gaps in care report to do the follow-up promised in the Plan.

## IV. Recommendations

The DSS Health Plan includes many of the components needed to build a strong health care system for children in foster care. That said, we believe the Plan needs to be refined and built out, as noted in the early part of the report and again, in more detail below.

Our recommendations are organized around six pillars needed to support a robust health care plan for children in foster care. Relevant elements found in the original Plan can be dropped into this reorganized framework. In addition to reframing, the next version of the Health Plan should specify implementation timeframes, task owners, multi-year resource needs (staffing, technology, other) and identify where changed protocols and staff training will be needed.

In the short term, as noted earlier in the report, and most immediately, DSS should convene a group of high-level decision makers on a weekly basis to begin discussion and expedite action on the foundational components of the Plan. There is no need for to wait for Plan finalization and in fact, getting started on these activities now, will inform and strengthen the next version of the Plan. Acting promptly will offer SCDSS an opportunity to identify operational challenges early and incorporate mitigation strategies into the Plan.

We have organized our recommendations into six pillars:

1. Governance
2. Data Sharing and Reporting
3. Enrollment
4. Care Coordination and Care Management
5. Network Adequacy, Access to Services and Immediate Needs
6. Targets

### 1. Governance

- The SCDSS Health Plan builds on a model of shared services and differentiated capabilities across relevant state agencies and affiliated organizations. Successful Plan implementation will require a governance entity for coordination, troubleshooting and accountability. A governance structure

including DSS, HHS and other relevant state agencies is needed for accountability and to identify and resolve operational challenges through the course of the implementation of this plan. At this stage in the reform effort, an internal state agency-only governance group will need to meet monthly, at minimum, to plan, track progress, resolve disputes, design policies and reports, build out the specifications for the care coordination function and otherwise share responsibility for operationalizing relevant components of the Health Care Plan.

- To date, the Director of the Office of Child Health and Well-Being position has been posted but remains unfilled. This is a time-critical hire and recruitment of a highly qualified person is essential to securing dedicated, consistent and skilled leadership in a role that has been historically absent in South Carolina. In considering the responsibilities of the Director, it will be important to identify a person who is knowledgeable about the substance and mechanics of Medicaid, health care data, and care management models as well as someone who has a health-related background. A good candidate will also have strong project management skills as these are essential to implement the Health Plan, as well as the capacity to understand and engage within a broader reform strategy/context. We've submitted suggestions for the posting via email.

- Given the importance of data to the Plan, DSS will need to develop a clinically-oriented data team in this office tasked to work with HHS and SH, related departments at SCDSS and other affiliated entities. As well, this office would house the Medical Director, staff the Foster Care Advisory Committee (FCAC), run point for SCDSS on cross-system service coordination and collaboration with the SCDMH and its service continuum and SCDHHS on the development of the 1915(c) waiver protocols, develop policies and procedures and the health and behavioral health training protocols. This team would work with other SCDSS departments to develop dashboards, report templates, inform the QI process and assist with implementation of the SCDSS CSFR PIP.

- DSS needs to work **immediately** to develop a shared Governance agreement between SCDSS and SCDHHS with a defined role for SH, including a timeline for implementation and projection of resource needs. See the next section for more details on this.

**2. Data Sharing and Reporting**

- We suggest a reset in the relationship between DSS, DHHS and SH. The contract with SH is held by HHS but the customer is DSS on behalf of children in foster care. While DSS is ultimately accountable for meeting the health needs of children in their care, it depends on a strong partnership with HHS and SH to meet its obligations to children. A key component of the reset must be built upon a data-sharing agreement to be developed between the three parties to 1) facilitate completion of CAPSS records for each child; 2) flag, track and follow-up on youngsters identified with immediate needs; 3) insure timely screening and assessment by SH; 4) identify children in need of Intensive Care Coordination from SH; 5) allow for a targeted focus on the health and behavioral health care needs of children in foster care; 6) formalize channels of reporting and accountability.

- DSS needs to put in place the data sharing agreement ASAP. A very aggressive timeline for this would be six months to get the data sharing agreement completed and executed, test and adjust a live data feed and data exchange and begin to generate administrative reports. The data sharing agreement should cover data needed to populate CAPSS, data access permissions and restrictions

and include a list of monthly, quarterly, annually or more frequent administrative reports (more than one medication, immediate needs, etc.).

- Synchronize DSS, HHS and SH Timelines. DSS must synchronize its screening and service timelines with HHS and SH. Different standards related to appointment availability on the part of SH need to be reconciled with DSS requirements. Children in foster care will need some prioritization for screening and treatment services, especially upon initial entry into care based on the American Academy of Pediatrics standards, as noted above.

- Generate Data reports from HHS and SH. As an MCO, SH is already required to produce dozens of reports, and is subject to federal and state reporting requirements. In addition, SH told us that they themselves generate "gaps in service" reports for children in foster care. HHS also generates routine data reports, and has additional data on children in foster care (e.g., dental records). DSS needs to determine what can be gleaned from the HHS and SH reports to identify children who have not been screened, and/or are not receiving needed services, or who had adverse reactions to medication or treatment. In the long-term, administrative data reports could be generated by DSS based on the HHS/SH data used to populate CAPSS. Work with SCDHHS and SH to develop a set of templates and special reports and timetable for distribution and build out a monthly and quarterly performance review process. As part of our due diligence, we have requested that DSS obtain data reports from HHS and SH both to begin the process of identifying which children are in need of screenings and services, and to verify that the data is available and can be used to meet its obligations under the settlement agreement.

- In the short-term, we recommend that DSS request immediately from SCDHHS/SH a copy of the "gap in service" reports for children currently in care. In addition, while there are a number of descriptive aggregate data reports from SH that DSS and HHS will want to review over time (e.g., routine psychotropic medication reports; population with two or more chronic conditions; population with asthma diagnosis; etc.), at this point DSS should be requesting data to identify any outlier children or children who are missing screenings or needed services. Accordingly, we recommend that DSS request and review the gaps in service reports ASAP, as well as a report from SH that is focused on children from the original cohort in the case (approximately 2,000) to determine which of those children, based on the encounter and claims data, have not received required screening, assessments and follow up care.

- Consider time-limited staff sharing. DSS should consider embedding a staff person familiar with the MMIS from HHS and/or SH to DSS. This staff person(s) could also, as an interim fix to the problem of the 30-day enrollment lag, identify and record in CAPSS, for all new children who enter care (approximately 40 per month), their prior medical history as per HHS data, and ensure a smooth transition to SH for initial care coordination. This will accelerate the transition to the use of MMIS and SH data to populate CAPSS health records, track gaps in care and the development of reports and protocols and serve as a temporary bridge while enrollment lag issues are corrected.

- The revised Plan should include a timeframe, task owner(s) and resources needed for the development of a data-sharing agreement; a preliminary list of reports to be produced; a protocol and trainings developed for data management, data sharing, report distribution and other activities related to use of SCDHHS Medicaid and/or SH data for CAPSS and production of management reports including a timeline for implementation and projection of resource needs. See the next section for more details on this.

## 3. Enrollment

- DSS and HHS must address the 30-day time lag between entry into foster care placement and enrollment into SH as a high immediate priority. The vast majority of children coming into the foster care system are Medicaid eligible and already enrolled in one of the state's MCOs. Children entering foster care are automatically eligible for Medicaid but enrollment in the state's foster care MCO plan does not start the day the child enters care. One consequence of this lag is that the child may remain the responsibility of a non-foster care MCO making it difficult to ensure that 7-day, 72-hour and 30-day timeframes for assessment are completed, that immediate needs are identified and addressed and that follow-up is scheduled for all identified health and behavioral health needs. In South Carolina, children are assigned to a Medicaid MCO on a monthly basis. MCOs are paid a per member/per month rate. This means that, depending on the time of the month, for a child that enters foster care, there may be a time lag for them to be picked up as a SH member. Approximately 281 children enter foster care each month and it appears that lifting this administrative barrier would go a long way to satisfying several outstanding issues in the litigation.

- Ensure that all children coming into care have a Medicaid ID that includes a designation - - called a paycat - - that recognizes their foster care eligibility status to expedite enrollment in SH. (Although the majority of children enter foster care with an active Medicaid ID#, SCDSS and SCDHHS believe that 400 children have not been coded as eligible based on their foster care status.)

- The Plan should include the development of a new enrollment protocol that will eliminate or mitigate the 30-day enrollment lag for an estimated 51[2] children entering care each month, including a timeline for development and implementation of the protocol and identifying any resource needs in the revised Plan.

## 4. Care Coordination and Case Management

- Develop a shared and tiered approach to Care Coordination and Case Management between SCDSS and SCDHHS and SH including definitions, workflow protocols for DSS county case workers, regional IFCCS caseworkers, SH care coordinators and care managers and a timeline for implementation and the clarification and delineation of case management and care coordination responsibilities for both DSS and SH. SCDSS and SCDHHS should identify implementation resource needs.

- Implement SH Care Coordination. All children who enter foster care (approximately 281 children per month) need an early and basic level of care coordination to ensure that their initial screening and assessment is completed, and that any follow up services are put in place. In addition, DSS and SH should identify other routine milestone points for the review of all children by SH care

[2] DSS reported that 82% of children who entered care were enrolled in Medicaid already at time of entry. Based on 281 children entering care each month, this means approximately 51 are not enrolled in Medicaid already at time of entry.

coordination. (DSS must ensure that SH follows the American Academy of Pediatrics Bright Futures recommended screenings, health promotion, anticipatory guidance and health supervision). Finally, the data reports described above should identify children that are already in care who have unmet screening and service needs, and therefore need immediate attention from SH care coordination (and possibly, per below, SH Intensive Care Coordination).

- Define and Implement SH Intensive Care Coordination. DSS and SH must agree on a validated level of need assessment tool to identify DSS children who require "Intensive Care Coordination" (ICC), a function already developed at SH. Currently, SH identifies --using its own criteria-- children in foster care in need of ICC. DSS, HHS and SH need to work together to develop agreed upon criteria for children who qualify for ICC (e.g., children with a certain chronic health care condition). Finally, it will be important to develop a plan to identify how children already in care will be identified for ICC (in our focus group in South Carolina, we met two TFC foster parents who are receiving – and very happy about – ICC from SH).

- Define DSS Case Management and Revisit Tiered Design. DSS case workers are ultimately responsible to ensure that children in foster care receive the health care they need. A detailed scope of work, roles and responsibilities, work flows and relationship of DSS and IFCCS caseworkers and their relationship to SH care coordinators needs clarification and further definition. Moreover, we think the tiered design of DSS case management warrants a review. Currently, there are two types of caseworkers at DSS. SCDSS county-based caseworkers and regionally-based IFCCS workers. Our understanding is that the IFCCS is a vestige of the state's coordinated system of care project that required staff to have behavioral health expertise. IFCCS workers are assigned to children with SED - the highest level of need, but can also be assigned to medically fragile children or children with other special needs. IFCCS workers also carry cases of foster children (1:9) whose care is cross-subsidized by multiple state agencies: special education placements, dual diagnosed. Children placed in residential schools may be served out of state or in remote counties so IFCCS workers' smaller caseloads and duties around case planning and consultation are intended to leave time for traveling long distances that the workload of DSS county caseworkers cannot support.

  Children are referred to IFCCS based on the county worker and supervisor's assessment of their level of need, but typically do not get transferred from a county worker to an IFCCS worker, which is regional, until at least 35 days after they have entered care. There are expectations that the IFCCS worker will have additional care management responsibilities, including more frequent contacts, case consultation with schools and service coordination activities, though they are flexible by case.

  There are several reasons for concern about any bifurcation of casework resources, including that it can create case assignment inefficiencies and accountability challenges with a transfer from county to regional case management. Also, IFCCS eligibility is open to interpretation with a potential for creating long waiting lists or over/underserving serving children in care. It appears that county caseworker shortages and the poorly articulated residential continuum may have created a work-around centered on IFCCS.

- Building on the above, we note a gap in care filled by the IFCCS workers as relates to what appears to be an insufficiently differentiated continuum of clinically-oriented residential programs, very limited access to PRTF beds and group and congregate care settings which are prohibited from

offering on-site health or behavioral health services or staffing with clinically expert treatment teams. Exploration of the rationale for this prohibition is beyond the scope of this study. This also raises concerns about the adequacy of the health and behavioral health services and supports offered to children in group 2 and 3 congregate care beds. A starting point for review might be a data request from DSS to HHS/SH asking for a report on key health/behavioral health indicators for children in residential care group homes 2-3. While this goes beyond our scope of review, we note that frequently during the validation work, children in group care were described as higher need than can be handled presently in either Therapeutic Foster Care or Level 1 group care. Typically, children in congregate care require some on-site medical/clinical support. This is an issue that warrants further review and consideration.

There is a complex interdependency between DSS and SH that warrants careful attention because of an important goal of Least Restrictive Environment (LRE). Work is needed to develop a plan that ties together the child's need for a therapeutically-oriented placement and the assignment of a DSS county or IFCCS case worker and a SH care coordinator/care manager to accomplish the following: 1) complete timely level of need/level of care assessments, 2) assign county or IFCCS caseworkers, 3) assign SH care coordinators and determine appropriateness of SH utilization reviews, prior authorization and other LOC/LON determinations, 4) clarify workflows differentiating the roles and duties of IFCCS caseworkers, DSS caseworkers and SH care coordination for children placed into group care 2-3, residential schools, PRTF, and therapeutic foster family care, 5) determine eligibility for ICEDEC funding where state funds are pooled to cover the placement, tuition, treatment or other costs of placement. These are multifaceted issues, but because the IFCCS is an important resource and because IFCCS workers may, down the road, play a role in LRE placement, these issues warrant consideration and resolution.

As an immediate starting point, it would be useful to align timeframes for IFCCS eligibility with other health, behavioral health and dental assessments happening within the first 30 days of placement in foster care that are conducted by SH or other providers and consider the use of a standardized assessment tool like CALOCUS or CAFUS or CANS. This will necessitate resolution of the 30-day enrollment lag into SH, resolution of level of need assessments and determinations and level of care approvals by SH as discussed in other sections of the report.

**5. Network Adequacy, Access to Services, Screening and Immediate Treatment Needs**

- Standardize health and behavioral health care screenings and assessments offered through SH providers (Q-TIP and other designated preferred providers who are committed to and proficient in the American Academy of Pediatrics Bright Futures framework for health supervision) through use of validated screening and assessment tools (trauma, CALOCUS, CANS, CAFUS, depression, etc.). This should include an assessment and possible augmentation of reimbursement rates paid for screenings and assessments.

- Include in the revised Plan, a timeframe for developing and implementing an approach to identifying additional Q-TIP or Q-TIP-like providers and an estimate of resources needed to do so. The Plan should also speak to the issue of provider assignment to enable SCDSS and SH to assign more foster children to a preferred provider and address logistical challenges associated with Q-TIP provider assignment: travel and transportation access, current practice by foster parents who now choose the child's health care provider – that will need further attention. We suggest that

DSS include in the Plan a mechanism for engaging foster parents and the FCSC to inform the resolution of these issues.

- Develop a process with SCDSS, SCDHHS and SH for an annual review of network capacity and access to services including a projection of resources needed for implementation activities. Include a timeline for the implementation and development of a protocol and monthly report to track, flag and prompt timely completion of health, dental and behavioral health screenings and assessments, referrals and follow-up needed and to identify immediate needs and gaps in care.

  Note: The question about additional training, quarterly/semi-annual convenings (Grand Rounds, meet and greet, etc.) and increased rates for providers that serve children in foster care is one that HHS seemed open to discussing. We raised an issue about a rate that was quoted to us by one provider that seemed low, and they told us they were aware of the issue and were working on it. From our perspective, DSS will be a better position to advocate with respect to provider rates once it has access to Medicaid data, which will show more reliably the types of screenings and services happening for children in custody.

**6. Targets**

As noted previously, there is an urgent need to align and synchronize DSS, HHS and SH timelines for screenings, assessments, and immediate treatment needs. Jointly with the co-monitors, DSS needs to engage with DHHS and SH to arrive at proposed target dates and benchmarks for completion of screenings, assessments, referral for follow-up and immediate treatment needs.

## Appendix I. Interviews

Advocates:

- Erin Hall, CEO, Palmetto Association for Children & Families
- John Shackelford, Director of Government Relations, SC Youth Advocate Program (SC YAP)
- Advocate, Protection & Advocacy for People with Disabilities, Inc.

Foster Parents:

- John Shackelford, Director of Government Relations, SC Youth Advocate Program (SC YAP)
- TFC parents from SCYAP

Medical Professionals:

- Dr. Libby Ralston, Co-Director, Project BEST
- Dr. Elizabeth Wallis, Medical Director, MUSC Foster Care Clinic
- Dr. Olga Rosa, Pediatrician, Palmetto Health Richland

Plaintiffs:

- Stephen Suggs, Appleseed
- Dione Brabham, Appleseed
- Sue Berkowitz, Appleseed
- Erin McGuinness, Children's Rights
- Ira Lustbader, Children's Rights
- Stephanie Persson, Children's Rights
- Matthew Richardson, Wyche

SCDSS:

- Susan Alford, Director, SCDSS
- Taron Davis, Deputy State Director of Child Welfare, SCDSS
- Tammy Bagwell, QA Director, SCDSS
- Holly Pisarik, Internal Monitor, SCDSS
- Diana Tester, Data Coordinator, SCDSS
- Malik Whitaker, Director of Continuous Quality Improvement, SCDSS
- Paulette Salley, IT Director, SCDSS
- Dr. Anita Khetpal, Consultant Psychiatrist, SCDSS
- Jonnieka K. Farr, CAPSS IT SCDSS
- Brad Leake, Data and Accountability Director, SCDSS
- Tim Nix, Lead Clinical Specialist, SCDSS
- Robert Linares, Contract Administrator, SCDSS

SCDHHS:

- Andrea Bickley, Director of Health Informatics & Analytics, SCDSS
- Peter Liggett Deputy Director, Behavioral Health & Long Term Care SCDHHS

- Brian Amick, Deputy Director for Health Programs, SCDHHS

SCDMH:

- Mark Binkley, Medical Director, SCDMH
- Debbie Blalock, Executive Director, SCDMH
- Louise Johnson, Director of Children's Services, SCDMH

SelectHealth:

- Rebecca Engelman, Market President, SelectHealth
- James King, Contract Account Manager, SelectHealth

USC:

- Dr. Cynthia Flynn, USC Center for Child and Family Studies, USC
- Suzanne Sutphin, USC CCFS

## APPENDIX II. Documents Reviewed

- Group Homes with Levels as of 1/10/2018
- Directive Memo – Immediate Implementation of the Education and Health Passport May, 2016
- South Carolina Department of Social Services Health Care Oversight and Coordination Plan 2015-2019
- 2018 PAFCAF Legislative Priorities
- AAP Periodicity Schedule (Recommendations for Preventative Pediatric Health Care)
- Chapter 7 of the Child Protective and Preventative Services Policy Manual on Babynet Referrals
- Child and Adolescent Level of Care Utilization System (CALOCUS) manual (10/17/2010)
- CAPSS Immediate Treatment Needs screen
- CAPSS screen of Healthcare Passport 10/21/2016 from test site
- County Service Array Survey, Appendix to the Placement Needs Study
- Director of Wellbeing job announcement
- Chapter 8 of the DSS Foster Care Policy Manual on Foster Care and on the Education and Health Passport
- Foster Care Health Advisory Committee Meeting Minutes from 10/04/2017
- South Carolina Department of Health and Human Services Medicaid Policy and Procedures Manual Chapter 204 on MAGI Eligibility Categories
- South Carolina Department of Health and Human Services Medicaid Policy and Procedures Manual Chapter 502 on Foster Care and Adoption
- Healthcare Needs Assessment Analysis from the South Carolina Department of Social Services Healthcare Workgroup, 04/2017
- Immediate Treatment Needs (List of Definitions from Michelle H., Medicaid and an operational definition)
- Directive Memo – South Carolina Department of Social Services Immediate Treatment Needs Practice Directive and Policy Change Announcement 11/15/2017
- Initial Healthcare Screening Reports Summary
- Medicaid Guidelines for Dental Care
- Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents 09/2013
- Medicaid Spending on Children in Foster Care by County – Per Child Per Month, Aggregate Data, 12/28/2017
- Michelle H. Initial Complaint
- South Carolina Department of Social Services organizational/staff chart
- South Carolina Department of Social Services Education and Health Passport
- Section 2 of the Physicians Provider Manual
- Service Array Codebook
- South Carolina Department of Social Services Human Services – Foster Care Children Immediate Treatment Needs Summary Report as of 12/11/2017
- South Carolina Department of Social Services Human Services – Foster Care Children Immediate Treatment Needs Summary Report as of 12/18/2017

- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 09/24/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/02/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/09/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/15/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/22/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/29/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/06/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/12/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/19/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/26/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/04/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/11/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/18/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 05/01/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 06/05/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 07/03/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 07/31/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 08/07/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 09/24/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 10/03/2017
- Placement Needs Assessment Baseline Study Final Report, 08/31/2017
- Placement Needs Assessment Report; Appendix B, Appendix C, Appendix D, Appendix E, Appendix F, Appendix G and Appendix H

- South Carolina Department of Social Services Child Welfare Quality Assurance Review Report: Greenwood County, 05/2016
- Greenwood County Comparison Chart
- Greenwood County Quality Assurance Review Summary Case Notes
- CAPSS Health Care and Well-Being User's Manual
- Immediate Entry of Initial Medical, Dental, and Behavioral Health Information
- Michelle H. Settlement Healthcare FAQ's
- Foster Care Children Psychotropics Medications CAPSS extract, 12/2017